

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036352
5090 STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5090

FILED OCT 7 1963

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 6 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Osteopathic Hospital		d. STREET ADDRESS (If outside, give location) 1001 Prospect	
3. NAME OF DECEASED (Type or print) First MAGGIE Middle HATTIE Last NORRIS		4. DATE OF DEATH Month 9 Day - 17 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-21-83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	9. AGE (last birthday) 79
11a. FATHER'S NAME Wesley Knickerbocker		11b. MOTHER'S MAIDEN NAME MARCELLA BARNES	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT KATHERINE MORRIS - 1001 Prospect	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure + shock DUE TO (b) Cerebral Thrombosis DUE TO (c) Cerebral Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senility		INTERVAL BETWEEN ONSET AND DEATH 6 hours 9-5-63	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 9-5-63 , to 9-17-63 and last saw her alive on 9-17-63 Death occurred at 10:30 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE G. N. Gillum M.D. (Degree or title)	
22b. ADDRESS 926 E. 11th, Kansas City, Mo.		22c. DATE SIGNED 9-17-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 9-19-63	
23c. NAME OF CEMETERY OR CREMATORY UTICA CEMETERY		23d. LOCATION (City, town, or county) (State) UTICA MISSOURI	
24. FUNERAL DIRECTOR Gordon Funeral Home		25. DATE RECD. BY LOCAL REG. 9-17-63	
26. REGISTRAR'S SIGNATURE Bessie Smith			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF
G. N. Gillum
MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or, by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Forest D. Coldenow

Licensed Embalmer No. 4714

P. O. Address KE 4110

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.